

Exhibit 6

**MUST BE
POSTMARKED NO
LATER THAN
April 17, 2017**

United States District Court
Southern District of New York

ABDCA54131
**FOR INTERNAL USE
ONLY**

Mahoney v. Endo Health Solutions, Inc., et al.
Case No. 15-cv-9841 (DLC)

INSTITUTIONAL OPT OUT FORM

INSTRUCTIONS FOR SUBMITTING A REQUEST FOR EXCLUSION

If you are an insurer, third-party payor, or other corporate entity, and wish to request exclusion from the Settlement Class, you must complete this form in its entirety. Requests for exclusion must be postmarked no later than April 17, 2017, and mailed to:

Fluoride Tablets Settlement
EXCLUSIONS
c/o A.B. Data, Ltd.
P.O. Box 173017
Milwaukee, WI 53217

Please contact the Claims Administrator at 1-800-983-6133 with any questions.

ATTENTION: THIS FORM IS TO BE FILLED OUT ONLY ON BEHALF OF INSURERS, THIRD-PARTY PAYORS, OR OTHER CORPORATE ENTITIES. INDIVIDUAL CONSUMERS DO NOT NEED TO COMPLETE THIS FORM

Section A: Identification

Company or Health Plan Name

Contact Name

Mailing Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used.

☐ Health Insurance Company/
HMO
 ☐ Self-Insured
Employee Health Plan
 ☐ Self-Insured
Health and Welfare Fund

☐ Other (Explain)

Section B: Amount Paid

Please type or print, in the box below, the total amount of out-of-pocket expenditures for purchases or reimbursements of Chewable Tablets between October 31, 2007, through December 31, 2015. This total amount equals the total paid or reimbursed minus any discounts, rebates, samples, and reimbursements and net of co-pays, deductibles, and co-insurance.

Chewable Tablets	TOTAL AMOUNT PAID
Purchases or Reimbursements from October 31, 2007 through December 31, 2015	\$

Section C: Certification

I under penalty of perjury that the above information supplied by the undersigned is true and correct to the best of my knowledge and that I am authorized to act on behalf of the insurer, third-party payor or other corporate entity identified herein ("Company"). This Institutional Opt-Out form represents the intent of the Company to request exclusion from *Mahoney v. Endo Health Solutions, Inc., et al.*, Case No. 15-cv-9841 (DLC). This Institutional Opt-Out form was executed this ___ day of _____, 201 .

Signature

Print or Type Name

Mail the completed Institutional Opt-Out form postmarked on or before April 17, 2017, to the following address:

Fluoride Tablets Settlement
 EXCLUSIONS
 c/o A.B. Data, Ltd.
 P.O. Box 173017
 Milwaukee, WI 53217